Washington State Department of Health

Medical Assistant-Phlebotomist Certification Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Medical Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instruction Checklist

Important background check information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee: (This fee is non-refundable).** You can check the online fee page for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of Legal Name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year you were born.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information about your certification. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change, See WAC 246-12-310.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must provide the documentation listed in the note after the questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Training and Education**
List in date order your training and education and practice. Attach additional pages if you need more space.

☐ **4. Experience**
List in date order your professional work experience. Attach additional pages if you need more space.

☐ **5. Other License, Certification, or Registration**
List all states where you hold or have held a credential.

☐ **6. Qualifications and Training Attestation:**
You must meet the Qualification and Training Requirements. You must sign and date this as proof of completion.

☐ **7. Phlebotomy Training and Education—complete either a or b:**

a. You have successfully completed a phlebotomy program through a post secondary school or college accredited by a regional or national accrediting organization recognized by the U.S Department of Education.
See **WAC 246-827-0400(1)**
Note: You must have your official transcripts mailed directly to the Department from your post secondary school or college.

OR

b. The health care practitioner who supervised the phlebotomy training program must sign and date this as proof of completion.

☐ **8. Aids Education and Training Attestation**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **9. Applicant Attestation and Signature**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

Credentialing Requirements

Thank you for applying to become a medical assistant-phlebotomist in Washington State. In order to qualify for certification you must complete the following.

☐ Complete and submit the application, with a original signature, date, and **fee**.

☐ Sign and date the application as proof of:

- Completion of high school education or its equivalent.
- The ability to read, write, and converse in the English language.

☐ **Education and Training:**

a. Successful completion of a phlebotomy program through a post secondary school or college accredited by a regional or national accrediting organization recognized by the U.S. Department of Education. Have your accredited post secondary school or college mail your phlebotomy program official transcripts directly to the Department with the date of completion listed.
Or;

b. Successful completion of a phlebotomy training program as attested by the phlebotomy training program's supervising healthcare practitioner.
Or;

c. Military training or experience satisfies the training or experience requirements unless the secretary determines that the military training or experience is not substantially equivalent to the standards of this state. Provide official transcripts showing proof of your education, training, and experience.

☐ **Experience:**
List in date order your professional experience and practice from date of completion from your accredited phlebotomy program or phlebotomy training program. Include the month, day, and year. Attach additional pages if you need more space.

☐ Seven hours of AIDS education and training as required under **WAC 246-827**.

☐ Out-of-State Credential Verification form sent to each state where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly back to Washington State.

Note: You may not practice as a medical assistant-phlebotomist without a valid credential.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0252625081

Medical Assistant-Phlebotomist Certification Application

Please type or print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ..... ☐ ☐

3. Training and Education

List in date order your training and education. Attach additional pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

4. Experience

List in date order your professional work experience and practice. Attach additional pages if you need more space.

Name and Location of Institution	From (mm/dd/yy)	To (mm/dd/yy)	Type of Experience or Speciality

5. Other License, Certification, or Registration

List all states where you hold or have held a credential.

State/Jurisdiction	Credential Type	Credential		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grandparented

6. Qualifications and Training Attestation

I certify I have completed each of the requirements below.

- Proof of a high school diploma or equivalent;
- The ability to read, write, and converse in the English language.

Applicant's Initials	Date

7. Phlebotomy Training and Education—Complete either a or b.

A. Phlebotomy Program through an accredited post secondary school or college

I certify that I have successfully completed a phlebotomy program through a post secondary school or college accredited by a regional or national accrediting organization recognized by the U.S. Department of Education. See **WAC 246-827-0400(1)**.

Note: You must have your official transcripts mailed directly to the Department from your post secondary school or college.

Signature of Applicant _____ Date _____

B. Phlebotomy training program supervised by a health care practitioner

The medical assistant-phlebotomist shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency.

I, _____ certify that _____
(Phlebotomy training program's supervising health care practitioner) Medical-assistant phlebotomist name

completed training as required by **WAC 246-827-0400(2)**.

Signature of health care practitioner _____ Date (mm/dd/yyyy) _____

License Number _____ Expiration Date (mm/dd/yyyy) _____

8. Aids Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Name of Applicant)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

by:_____
(Original Signature of Applicant)

Washington State Department of Health
Medical Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered. Instruct them to return the form directly to the address listed above. Licensing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process. This form may be duplicated.

Name: Last First Middle		
Mailing Address		
City	State	Zip Code
Any other names used:		
Credential Number		Date Issued

Have the licensing agency return this completed form to the address listed above.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no", please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

(SEAL)

Signature: _____

Title: _____

Date: _____

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Medical Assistant Law, RCW 18.360

Medical Assistant Rules, WAC 246-827

On-line

AIDS Training Resources, Reference Page

Medical Assistant, Web Page

List-Serv

To receive emails regarding important medical assistant information, please join our interested parties on our List-Serv.